Co-Constructing the "Good Mother" in Doctor-Mother-Paediatric Patient Interactions

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DECLARATION

I, Candice Ann Harrison-Train, hereby declare that this research report is my own unaided work. It has not been submitted on any prior occasion for any other degree or examination at any other university.

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1 INTRODUCTION

This study employs conversation analysis (CA) and membership categorization analysis (MCA) in an exploration of the interactional organization of talk between doctors and the mothers (or the female guardians acting as "proxy mothers") of HIV-positive child patients being treated at a paediatric hospital in the Western Cape, South Africa, in 2003.

The analysis focuses on how the HIV paediatric consultation is co-constructed between the doctor and the mother/guardian, and how interactional choices on the part of the participants shape the course of the consultation. Specific attention is placed on how participants orient to, hear, respond to and co-construct the category of "mother", along with the emergent inferences of what constitutes "good mothering" in the context of pursuing the wellbeing of the HIV-positive child who - as it emerges in certain cases - has evidently been infected by the mother in the first instance. As such, this study examines interactions in which the young child patients fall within the category of "the HIV-positive child", and one of the inferences associated with this category is the eventuality that the "positiveness" of the child is associated with the "positiveness" of the mother who, in turn, by reference to her own category as "mother" is both the "infector" and "protector" of the child in the mother-child unit. This ambiguous status on the part of the mother sets the stage for perceptible recurrent orientations to the "good mother" identity, thus providing

a striking opportunity to examine how a “desirable” identity is co-constructed, maintained and defended.

As its core focus, this study examines how orienting to “good mothering” is *done* - in a moment-by-moment, collaborative and co-constructed manner – in the immediate course of the doctor/mother/guardian consultation. This involves considering the interplay of shifts in orientations to “motherly responsibility” and “doctorly responsibility”, and how these shifts are collaboratively activated, negotiated and responded to, as the consultation proceeds.

At the time that these medical consultations took place, 30% of all people in the world living with HIV/AIDS were located in Southern Africa, which then housed less than 2% of the world’s population (World Health Organization & UNAIDS, 2003). Further, unlike any other region in the world, women were at least 1.2 times more likely to be infected with HIV than men and – amongst those in the 15- to 24-year old age group – were two and a half times more likely to be infected than men (World Health Organization & UNAIDS, 2003).

In South Africa, in particular, the HIV prevalence rates amongst pregnant women attending antenatal clinics in 2003 were between 22% and 25% (World Health Organization & UNAIDS, 2003). According to the Global HIV/AIDS Response Progress Report (2011), South Africa was one of the few countries in the world in which child and maternal mortality rates increased in the 2000s, and this was largely attributed to HIV/AIDS. In the case of infants

and children, HIV acquisition was primarily through mother-to-child transmission, either *in utero*, during the birth process, or through breast-feeding.

Before 2003, South Africans with HIV could access treatment for opportunistic infections resulting from the weakening of their immune systems, but could generally not access anti-retroviral therapy (ART) through the public health system, although there were a few exceptions to this, including the paediatric hospital from which the data for this study were obtained. As such, the children receiving treatment in the consultations examined in this study were part of a small cohort with access to the full spectrum of HIV services, not yet more widely available at the time.

Within this overarching context, this study seeks to contribute to the considerable body of CA literature on doctor-patient interactions, the largest proportion of which has sought to make conversation analytic contributions to the wider field of health communication, and the implications of doctor-patient interactions for positive patient outcomes.

The next part of this study (Section 2 below) provides a literature review that, firstly, examines studies in mothers' orientations to the ideals of "good motherliness" (including some studies considering HIV-positive mothering), and ways in which these ideals are used as the basis for constructing, negotiating, re-defining and re-aligning "good motherly" identities. The second component of the literature review examines MCA studies on "identity" as fluid

and negotiated, but with specific analytic emphasis on ways in which identity categories are *enacted* and oriented to on a moment-by-moment basis in the course of immediate and "naturally-occurring" interaction, as it unfolds. The final component of the literature review examines a selection of CA studies on doctor-patient interaction and doctor-parent-patient interaction, all of which focus on the examination of specific moments in the medical encounter that explicate how some bits of interactional business are achieved, in the moment.

Section 3 outlines the methods employed for this study, and provides an elaboration of the analytic framework for the ensuing analysis, including an outline of both CA and MCA frameworks, and a consideration of their complementarities in the analytic process. Section 4 provides the analysis of the data extracts selected for this study, and Section 5 provides a concluding discussion of the emerging findings and their potential contributions to the CA/MCA bodies of literature.

2 LITERATURE REVIEW

This literature review is composed of three sections, the first of which (Section 2.1) briefly examines the notion of "good mothering" and "good mothering" identities, and considers a set of studies that examine ways in which mothers strive to attain and maintain membership of this idealized category, including studies conducted specifically in the context of HIV. Section 2.2 briefly examines MCA literature on identity categories, with specific analytic focus on

how any immediate identity is worked up and achieved in the moment-by-moment and co-constructed course of naturally occurring interactions.

The third section of the literature review (Section 2.3) specifically addresses CA literature on doctor-patient interactions, including doctor-parent-child patient interactions, and how these are co-constructed between the participants, as well as how this co-construction shapes the course of the consultation.

2.1 On the Burden of "Good Mothering"

While the construction of "the ideal" is a social act, and one that is subject to variations in cultures, traditions and moralities, the ideal of the "good mother" is most often expressed as one in which the mother is considered to be primarily responsible for protecting, nurturing and developing the "sacred child" (Johnston & Swanson, 2006, p. 510), and in a manner in which the child's needs are seen to override the mother's needs (Johnston & Swanson, 2006).

This section of the literature review is not concerned with further defining, refining or contesting what constitutes "good mothering". Rather, it is concerned with studies that examine ways in which mothers seek to attain and maintain identities as good mothers in contexts where reaching this ideal may be subject to compromise. While none of the studies discussed below are specifically conversation analytic in nature, they do speak to how

positioning with regards to “good mothering” is enacted, albeit not through the analysis of the moment-by-moment co-construction of an interaction.

In one such study on positioning towards “good mothering”, Bell (2003) examines how a sample of mothers found ways to repair their damaged identities as good mothers – on disclosure of the incestuous abuse of their children – by appealing to a gendered ideal of “good mothering”, and using this ideal to elaborately justify their “not knowing”, and to bolter their positive acts of “good motherliness” in order to re-establish their status as good mothers.

Similarly, Kielty (2008) examines the narratives of two mothers not living in the same residence as their children – one who voluntarily left the child with the father, and one whose child was removed from the mother’s care by the father, against her wishes. Kielty suggests that the two women, despite the different reasons for their non-residence with their children, both manage their “atypical” situations (p. 363) by building their narrative justifications for their respective circumstances around mothering ideals. Kielty (2008) suggests that the women both engaged in “extensive discursive labor” (p. 363) in order to defend against a “bad mother” label, and to justify their courses of action as mothers.

Johnston and Swanson (2006), in turn, examine whether or not mothers’ “mothering ideologies” shape their courses of action with regards to seeking work, or visa versa. This study found that women who chose to be full-time

mothers tended to report that their decisions were based on their motherly ideals and convictions with regards to full-time parenting. In contrast, working mothers tended to report that their choices to work informed their mothering ideologies, rather than the other way round. The authors suggest that these ideologies, in turn, were re-constructed by working mothers to better fit with their choices to work, such that new “good motherly” ideals, which reconciled mothering and working, were formed.

These studies, then, suggest the fluidity of mothering identities and that, when these are compromised in relation to some or other “motherly ideal”, there is an effort on the part of the mothers to engage in processes to “repair” the motherly identity through re-constructions and re-alignments that seek to justify continued membership of the “good mother” category. Some of the studies point to the “labor” or “work” involved on the parts of the mothers to actively avoid the category of “bad mother”, or to regain access to the category of “good mother”. In the present study, the fluid and shifting nature of the motherly identity, and how this is achieved, is further explored.

Studies on notions of “good mothering” in the context of HIV are also of clear significance to the analysis undertaken in this study. The studies reviewed below consider the specific implications of enacting “good mothering” in an HIV context, in which the mother is physically compromised and stigmatized and, moreover, may have infected her child with the virus.

In a phenomenological study of American mothers with HIV, Nelms (2005) examines women's battles to comply with perceptions of "good mothering" in the face of their own ill health. The study examines the impacts of HIV-positive diagnosis on the study's sample of mothers, their struggles around whether or not to reveal their own status to their children, their guilt pertaining to having infected their children (where this was the case), and their daily battles to invest energy in nurturing and protecting their children. The study concludes that the trials of battling the disease, coupled with the pressures of "good mothering" result in some ambivalence with regards to their motherly roles and responsibilities.

Sandelowski and Barroso (2003), in an examination of the implications of mothering in the context of HIV infection amongst a sample of women based in the United States, consider the effects of the mothers' HIV status and HIV-related stigma on mothering. The authors found that motherhood, in this context, involved work towards two goals: the protection of their children (from HIV infection and/or from HIV-related stigma), and the preservation of a "positive maternal identity" (p. 470). This "mothering work", in turn, had the reportedly dual effect of giving the mothers something to strive for, while simultaneously drawing on their already compromised physical and emotional resources (resonant with Nelm's "ambivalent mothering" above).

The authors suggest that one of the key mechanisms employed by the HIV-positive mothers to counter the threats to motherhood (both threats to their health and social threats, such as stigma) was to engage in the practice of

"virtual" mothering (p. 476) – a concept which involves the integration of Goffman's "virtual identity" with the concepts of "eternal motherhood", "defensive motherhood", "protective motherhood" and "re-defined motherhood" (Sandelowski & Barroso, 2003). In essence, the authors argue that the mothers constructed a "virtual motherhood" identity – mothers who would always remain mothers, alive or dead - such that they conceived of motherhood as a "disembodied" (p. 476) or an unconfined, transcendent practice that would endure beyond their physical mothering. In this way, the mothers sought to reconcile the constraints on their physical health - and their possible deaths - with "good mothering" ideals.

Ingram and Hutchinson (1999a), in a study of HIV-positive women in the United States, argue that mothers are seen to adopt "defensive mothering" practices, which center around avoiding stigma, protecting their children's health, limiting damage (such as not permitting their children to use their toothbrushes, the sharing of which has been implicated in HIV transmission), and positively reframing both their HIV status and their motherly roles, such that they are able to re-construct their roles as mothers in a manner that integrates their identities as HIV-positive and their identities as "good mothers".

A further study on enacting mothering in the context of HIV involves the use of Goffman's ground-breaking work on stigma in an analysis of HIV-positive mothers' responses to avoiding being stigmatized (Ingram & Hutchinson, 1999b). Goffman defined stigma as an attribute that is "significantly

discrediting" (Parker & Aggleton, 2003, p. 14). This attribute, moreover, is used by society to reduce the "deviant" person, resulting in the notion of a "spoiled personality" for those who are stigmatized (Parker & Aggleton, 2003, p. 14). Goffman contends that the merits of appearing "normal", therefore, result in the acts of "passing" or "covering", whereby the afflicted individual attempts to bridge the discrepancy between their "virtual and actual social identity" (Parker & Aggleton, 2003, p. 14).

Using this framework, Ingram and Hutchinson (1999b) recount HIV-positive mothers' experiences of stigma, and examine their narrative reports of "passing" themselves as "normal" by, for example, not revealing their status, by taking their medication in secret, and so on. The authors also found that when mothers' HIV symptoms were visible, such as the excessive loss of weight, mothers engaged in acts of "covering", such as declaring they were trying to diet to lose weight, or by attributing their symptoms to other non-HIV causes. The study also examined cases in which the HIV-positive mother did not show obvious symptoms of infection, but where their visibly ill HIV-positive children potentially thwarted their efforts to "pass" as "normal". The authors found that in such cases, some mothers engaged in the additional act of "covering" in relation to their children to avoid both the mother and the child's concomitant stigmatization. These included attributing their children's illness to other diseases or ailments, such as ascribing a child's paralysis from HIV-related toxoplasmosis to a stroke.

The above studies, then, give insight into the ways in which mothers are seen to re-align and re-construct their identities as “good mothers” in the context of HIV infection, which include managing ways in which their “good motherliness” is specifically compromised by HIV-related stigma, the impacts of HIV on their physical wellbeing and energy, as well as the impacts of infecting, and then rearing, HIV-positive children.

All of the above studies on mothers’ identities are largely developed on the basis of mothers’ retrospective narratives, generated through researcher-driven processes, such as interviews and focus group discussions, explicitly designed to elicit mothers’ perceptions, reported experiences and stories of motherhood.

While these studies provide insight into how mothers’ identities are constructed, revised and reconstructed, this study seeks to examine how “good motherly” identities are *enacted* and *co-constructed* (by all parties in the interaction) on a moment-by-moment basis in the course of naturally-occurring interactions, as these progress. As such, this study examines how “identity-building” or “identity-shaping” is *done* in the immediate moment, even when the matter of the particular identity is not the main business at hand, but where *doing* that identity, at that moment, becomes relevant. Moreover, whatever is built on a moment-by-moment basis does not remain fixed and is, instead, oriented to, negotiated, shifted, claimed and resisted in a co-construction of every step or set of actions in the course of the interaction.

2.2 *DOING* IDENTITY

As outlined above, the present study examines how identity is enacted and co-constructed on a moment-by-moment basis. This section of the literature review briefly examines a small selection of MCA studies that exemplify the MCA approach to examining categories, including identity categories.

Using West and Zimmerman's (1987) notion of "doing gender" as an accomplishment of everyday interaction, Stokoe's CA and MCA work on gender moves away from exploring social identities as internal cognitive processes, and also moves away from notions of identity as "stable" and "essential" (Stokoe, 2010, p. 428) or "fitting into a causal matrix" (Edwards, 1998, p. 31). Rather, the analyst is concerned with a person's orientation to a particular identity or categorization that is evident and observable in the interaction, linked to the achievement of relevant actions in talk, in that moment. Thus, identity is not fixed and immutable, but involves "shifting selves, contingent on the unfolding demands of talk's sequential environment" (Stokoe, 2010, p. 428).

Butler and Fitzgerald (2010) focus on more "tacit" orientations to identities in everyday conversational settings, which are explored using a video-recording of a breakfast between family members, including a young child, his parents and grandparents. The authors focus on demonstrating (rather than simply asserting) how and when identities, such as "child" or "parent", become operative and find that these are not "merely invoked", but are generated in

the sequential production of social actions (p. 2472). Like Stokoe's (2010) notion of the "shifting selves", the authors find evidence that orientations to the categories of "host" and "guest" are also activated in specific sequences in which they become relevant, despite the dominant nature of the age and relational identities. The authors state that the analysis demonstrates how there is a "layering of category relevancies" (p. 2473) over the course of the interaction as a whole, and that various of these layers become relevant only at specific moments in the interaction.

Raymond and Heritage (2006), in turn, investigate how a woman's identity as a "grandparent" is co-constructed and sustained in a telephonic interaction with her "non-grandparent" friend. In this interaction, the issues of rights to knowledge and information emerge, such that both participants "monitor and assert rights to knowledge and information" - also on a moment-by-moment basis – and in a manner that involves mutual collaboration in the achievements of the tasks at hand. The participants, in effect, "police" the boundaries of knowledge and "claim special rights" (p. 700) thereto by virtue of their status as members (or non-members) of the category "grandmother".

The analysis of orienting to the "good mother" in this study also shifts from the consideration of identity as an internal, cognitive or psychological process, and examines the construction of the "good mother" in action, and in interaction, on a moment-to-moment basis. In this instance, the co-construction of the "good mother" takes place in the interactional interplay of

"identity as doctor" and "identity as mother", and the actions associated with asserting, aligning, claiming and disclaiming these.

2.3 An Overview of CA Literature on Doctor Patient Interactions

Relative to the inception of the tradition, CA has had a long history in the study of doctor-patient interactions in its "talk at work" foci, and has been contributing to the broader body of doctor-patient literature for now close to forty years (Heritage & Maynard, 2006a). As Heritage and Maynard (2006a) put it, reflection on doctor-patient interactions, and how these impact on health outcomes for the patient, is "undoubtedly as old as medicine itself, and recognition of its therapeutic power [of the doctor patient relationship] goes back to Hippocrates" (p. 354).

Non-CA methods for studying the doctor-patient relationship, and doctor-patient interaction, have their roots in both the quantitative and qualitative traditions (Roter & Frankel, 1992). Whilst Roter and Frankel suggest that research in the two traditions can inform each other - and the authors illustrate instances of what they term "method complementarity" (p. 1097) - the two traditions have generally developed separately.

Heritage and Maynard (2006a) suggest that the two streams of research into doctor-patient interactions can best be categorized as quantitative "process analyses", exemplified by the Roter Interaction Analysis System (a method of

coding and classifying medical dialogue against 39 categories), and qualitative “microanalyses”, which stem from the ethnographic interpretive paradigm. While acknowledging the separate contributions of these bodies of work, Heritage and Maynard (2006a) suggest that both streams of work have, however, failed to address how doctors and patients conduct themselves in “specific moments in the flow of the medial encounter” (p.361) and that they have not been able to make clear connections between factors that “putatively impact physician-patient interaction” (p. 361), or the relationship between how participants conduct themselves in the course of medical encounters, and how this, in turn, shapes the outcomes thereof.

It is suggested that CA provides one methodological technique that is able to capture and analyse these “specific moments” in the overall flow of the medical encounter, with a view to analysing interactional structure, choices and their outcomes, and is able to do so not through subjective interpretations, but based on the “directly observable properties of data” (Drew, Chatwin & Collins, 2001, p. 67), and how participants’ actions shape the co-constructed interaction.

ten Have (1995) suggests that early CA studies on doctor-patient interaction tended to focus on issues of asymmetry and power in doctor-patient interactions, wherein the doctors were construed as “oppressing” (p. 252) their patients through the imposition of their own medical frameworks on the patient and, thereby, constraining and curtailing both *what* patients are able to contribute to the interaction, as well as *how* they are able to make these

contributions. ten Have (1995) indicates, however, that CA work has increasingly focused on the ways in which both patients and doctors alike can use the institutional genre of the medical consultation to manage their own local agendas. As such, these studies have re-inserted the actions of the *patient* back into the analysis of the consultation, and have considered ways in which these actions also mutually impact on the shape and trajectory of the interaction.

Some of the literature that has focused on examining these local agendas on the part of doctors and patients alike include, for example, Heritage and Robinson's (2006) review of the "problem presentation" phase of the medical consultation, how doctors and patients co-construct this phase, and how patients use various interactional practices to validate and substantiate the visit, depending on their agenda. The analysis displays how patients are often primarily occupied with justifying decisions to receive medical help, and how they set about constructing "good enough" reasons to take the step of consulting a physician.

Boyd and Heritage (2006), in turn, conduct a detailed analysis of the history-taking component of the doctor-patient consultation, and explore how doctors and patients – in the question-answer sequences of history-taking – jointly construct a "medico-social course of action" (p. 183) that is not always constrained by the medical intents of the doctor's questions. So, for example, medical questions about alcohol use can elicit responses from patients in the

context of “sociability” rather than medical health. The co-constructed interaction, then, becomes “medico-social” in nature.

Robinson (2006) reviews how physicians’ solicitations of patients’ presenting concerns affect the ways in which patients present their problems. This is examined in the context of how patients orient to one of three types of reasons for visiting physicians, namely to present a new concern, to return for a follow-up on an existing concern, or to return for review of a chronic concern. The evidence emerging from this body of data displays how new concerns are often solicited by the doctor asking an open-ended question, such as “what can I do for you today?”, while follow ups and reviews of chronic illnesses – of which the doctor has prior knowledge – involve soliciting questions such as “anything new?”, which serve to invite the action of the provision of a specific update on a specific, and already-known condition.

Teas Gill and Maynard (2006) review how doctors and patients interact in the process of data gathering in the medical consultation. The authors suggest that patients show a reluctance to “compel an analysis” (p. 147) too soon, and support the elongation of the data gathering process by constructing their turns at talk in such a way so as to provide doctors with “sequential options other than immediately producing confirming or disconfirming assessments” (p. 147).

In another example, Drew (2006) reviews after-hours calls from patients to doctors, and reviews the patterns in which doctors and patients interact

around the perceived “normality” or “abnormality” of symptoms, and how each “resists…the other’s apparent assessment of the seriousness or urgency of the ailment/condition” (p. 444).

In line with the above, the analyses of the interactions examined in this study focus on how both the doctors and the mothers/guardians of the child patients activate and manage their own agendas in the interaction, and how each action undertaken to achieve the business of these respective agendas results in a progressive and mutual co-construction of the consultation. Further, the analysis also explores how and when the “medical” and “social” aspects of these agendas are taken up, expanded, rejected, diverted and avoided in the co-construction of what Boyd and Heritage (2006) refer to as a “medico-social course of action” (p. 183).

There is also a body of CA literature that focuses on doctor-parent-patient interaction - the patient in these cases being the child of one or both parents. These studies also focus on the co-construction of the medical encounter, and how interactional choices on the part of parents and doctors shape the course of the consultation.

One key ethnomethodological study on doctor-parent-patient interactions in paediatric settings is Tannen and Wallat’s (1987) study which, using Goffman’s notion of “footing”, examines the burden placed on the paediatrician in encounters between doctors, child-patients and parents, as the doctor “shifts frames” between the child and the parent (p. 205). This

frame shifting is seen to impact on the selection of “linguistic cues and ways of talking” (Tannen & Wallat, 1987, p. 215), and the authors suggest that their analysis provides an answer to doctors’ calls for a better understanding of the use of language in order to improve services in the medical profession.

Tates and Meeuwesen (2001) also reflect on the way in which doctors switch to “motherese” when talking to children in paediatric interactions, which the authors describe as being characterized by a more affectionate and playful conversational style, and who then revert to “doctorese” in the ensuing interaction with the parents. Further, the authors consider how the child-patient is “silenced” in the interaction, and suggest that studies that have paid attention to the structural aspects of doctor-parent-child interaction (in terms of turn-taking) have found that the *parents* appear to be primarily responsible for excluding their children from the ensuing interaction by way “interfering” (p. 846) in the doctor’s turns-at-talk directed specifically at the child and, thereby, diverting the ensuing talk back to themselves.

In a related study, Tates, Meeuwesen, Elbers and Bensing (2001) analyse the ways in which parents restrict their children’s interactions in the medical consultation, and how the doctors, in turn, follow this lead and orient themselves to a primarily dyadic interaction between themselves and the parent/s. As the authors observe, “parents obviously regard matters of the child’s health as their own responsibility” (p. 115) and, consequently, they are seen to sideline the child in the interaction, and treat them as though they were absent.

The preponderance of this tendency towards a dyadic interaction between the doctor and the mother/guardian is evident in the extracts analysed in this study, and interactions with the child tend to take either the form of the mother instructing, silencing or disciplining the child or, alternatively, the doctor (often playfully, as suggested by Tates and Meeuwesen, 2001) engaging the child in the actions required for the completion of the medical examination (such as the removal of clothing, standing on a scale for weighing purposes, etc.). The analysis, however, does not focus on the interactional role of the child in the consultation. Rather, the emphasis is placed on orientations to the mother or guardian's "good mothering" role in assuming responsibility for the child patient's overall wellbeing, as well as supporting the child's HIV treatment.

Also on issues pertaining to the parental role, Stivers (2002a, 2002b and 2006) has completed a series of studies on how treatment decisions are negotiated between parents and doctors, rather than these being "delivered autonomously" (Stivers, 2006, p. 311) by the doctor. Stivers (2002a) considers, for example, how parental presentation of "symptoms only" or further engagement in providing possible diagnoses can affect how doctors diagnose and treat the child patients, and can affect whether or not doctors prescribe antibiotics. Stivers (2002b and 2006) also considers how the negotiation between doctors and parents can result in instances in which the pressure brought to bear by the parents in the interactional process can result in questionable treatment plans on the part of the doctor and, in some cases

under review, the offering of "(sometimes major) concessions and inappropriate prescriptions" (Stivers, 2006, p. 311).

In the analysis undertaken in this study, parental pressure with regards to the ultimate treatment decisions on the part of the doctor is evident in a small number of cases (which are not addressed in the analysis), such as one mother's insistence for obtaining a specific "cream" or "lotion" for rashes that the doctor considers non-problematic. However, in most cases in the full body of data, this treatment-decision terrain is not contested. However, the mother/guardian's role in being responsible for their child's medico-social wellbeing is an issue that emerges in a number of the extracts. What plays out is less a case of mothers/guardians "interfering" in treatment decisions but, rather, courses of action that seek to demonstrate the mother/guardian's attentiveness to the child's wellbeing, and compliance with previously given "doctor's orders". It is these cases that receive attention in the analysis, as orientations to "good motherliness" become evident in the co-construction of these interactions.

In a review of CA's contributions to the study of doctor-patient interactions, Pilnick, Hindmarsh and Teas Gill (2009) suggest that in the previous 15 years, there has been an increase in health-related interaction studies that focus beyond the doctor-patient interaction, including studies in ante-natal screening, anaesthesia, counselling and related types of physical and psychological health services. One such study – and one of the few CA contributions to interactions in the context of HIV/AIDS – is Silverman and

Peräkylä's (1990) analysis of how HIV/AIDS counselling (in English clinics) necessitates communication about the "delicate" issues of sex and death. Their observations emerging from the counselling session data include the typical pauses and delays in talk, or the use of "er"s and "um"s, before mentioning terms about sexual intercourse, illness and dying – what the authors term "pre-delicate perturbation" (p. 296). Using the analytic technique of MCA, the authors note that "perturbations" preceding the introduction of a "delicate matter" are not sufficiently explained by psychological "embarrassment" or similar cultural issues. Rather, they pertain to the "moral baggage" (p. 304) that is carried with each label or membership categorization device, and the discomfort stems less from relations implied by the categorization, but rather the business of categorizations *as such* in which "both parties subtly attend to the local consequences of the labels they use to describe people and, by implication, themselves" (p. 307).

In the analysis that follows in this study, the thorny issues take something of a different form from the HIV counselling study above. In one of the interactions examined in detail here, the "moral baggage" being negotiated is one remove from the initial (likely sexual) point of virus contraction on the part of the mother. The primary nexus of the "thorny issue", rather, is the mother's concomitant transmission of the original infection to her child. While in this case it is argued that embarrassment - or, even more accurately – shame and stigma are seen to play out, the actions undertaken to co-construct and maintain membership of a "good" category (the "mommy protector") as a foil

to the “bad” (the “mommy infector”) serve as one analytic focus of *doing* categories.

While some of the above studies have moved away from a narrow focus on the “oppressive asymmetry” of the doctor-patient interaction, have re-inserted the actions of the *patient* back into the interactional agenda and its interactional course, and have emphasized the way in which the medical encounter is co-constructed between doctors and patients, a small number of other CA studies have returned to an examination of “asymmetry” in doctor-patient interaction. For example, Peräkylä (2006) examines the interactions between doctors and patients during the delivery and reception of diagnosis, and reflects on the way in which doctors “do” authority and patients respond to this authority in the medical consultation. Peräkylä’s analysis suggests that rather than the doctor’s authority being a tool of “medical-technical oppression” (p. 247), it is a “constitutive feature” (p. 247) of the medical interaction – one that is necessary for the effective achievement of the business at hand, and that does not necessarily result in poor doctor-patient partnerships.

Further, in a recent study, Pilnick and Dingwall (2011) note that despite considerable efforts since the 1960s to “reform” the perceived dominance of the doctor in what have been viewed as asymmetrical relationships of medical “oppression”, empirical evidence suggests that there still remains a “remarkable persistence of asymmetry” in which “more recent recordings of consultations sound, in many ways, very much like those of the 1970s” (p.

1374). Taking this as their starting point, the authors set about questioning the extent to which such asymmetries can be addressed through the reform of what they refer to as “talking practices” (p. 1374), or whether the phenomenon has deeper roots than such reforms could affect. The authors then turn to a review of CA studies on doctor-patient interaction, with a view to reflecting on understanding how asymmetry occurs in practice, and citing instances in these studies that illustrate how patients “*actively* defer to physicians” (p. 1378), both because they want an accurate diagnosis and because they recognize that “some degree of submission may be the most efficient strategy for achieving this” (p. 1378).

In the cases under examination in this analysis, the focus remains on the co-construction of the medical encounter. However, in line with the above, this does not preclude an examination of the asymmetries operational in the interactions. As emergent in the evidence examined here, a core focus is the interplay between “doctorly responsibility” and “motherly responsibility” and “institutional authority” and “social authority” in the context of the “medico-social” encounter. As such, the analysis seeks to illustrate that asymmetries in the doctor-patient interactions examined here do not consistently lean towards the “doctor” end of the spectrum. It is demonstrated, rather, that there are instances in interaction in which orienting to the “responsible mother” tips the asymmetry scale in the other direction.

3 METHODS

3.1 PROCEDURE

The data used in this research study were originally collected in 2003 for a study on communication in HIV/AIDS health care settings conducted by Professor Claire Penn, University of the Witwatersrand. The video- and audio-recorded data are currently housed in the Health Communication Research Unit (HCRU), University of the Witwatersrand. Permission was obtained from Professor Penn, the Director of the Unit, to utilize the video- and audio-recordings in the Unit's laboratory for the purposes of this study.

The original study selected an outpatient HIV/AIDS clinic within an urban tertiary level paediatric hospital in Cape Town, South Africa, and permission was obtained to make video- and audio-recordings of routine doctor-parent/guardian-patient and counsellor-parent/guardian-patient consultations, with a view to analyzing and exploring experiences of communication with regards to HIV/AIDS. In each case, the paediatric patient was an HIV-positive child, receiving treatment at the facility. Eleven caregivers, four counsellors and four doctors participated in the study, all of whom gave informed consent for their consultations or sessions to be recorded, as well as consented to participate in face-to-face interviews with the research team.

The present study considers only the recordings of the formal medical consultations between doctors, their child patients and their mothers or guardians (of which there was a total of 21 between the four doctors). It has purposefully excluded an examination of the face-to-face interviews between the doctors and the research team, as the focus of this study is directly on naturally occurring instances of doctor-parent-patient interactions, rather than on researcher-driven interactions, such as interviews.

The first procedure was to repeatedly review all of the video- and audio-recorded data available on the doctor-parent-patient interactions, as well as the pre-existing transcriptions of the data, which had been transcribed using traditional, non-CA transcription methods. These transcriptions were used as the basis for the development of selected transcriptions in line with the conventions that have come to be standard in transcribing data for use in CA, as developed by Gail Jefferson (2004). This involves not only capturing talk, but overlapping talk, delays, pauses, stress or pitch, loudness, prolongation of immediately prior sounds, non-speech sounds, including inhalations, exhalations, and so on (Jefferson, 2004).

While the data set contains innumerable areas of analytic interest in terms of doctor-parent-patient interactions, the evidence with regards to orienting to the “good mother” was particularly striking in two of the consultations under review, prompting more detailed focus on and examination of these, which has ultimately resulted in this study. The analyses of these cases serve as examples of the ways in which categories can come to be at stake for the

participants in an interaction, and how “identities-for-interaction” (Stokoe, 2012, p. 278) are co-constructed and brought to bear on the shape of any turn in talk, in the moment. While co-constructions of this type are evident elsewhere in the full body of data, only the strongest evidence for orienting to the “good mother” is considered here, and it is suggested that the analysis provides some possible insight into the how categorization is invoked, used, shaped and re-shaped beyond the idiosyncrasies of these particular interactions.

4 ANALYTIC FRAMEWORK

4.1 CONVERSATION ANALYSIS AND DOCTOR-PATIENT INTERACTION

Informed by Garfinkel’s ethnomethodological paradigm, which broadly refers to the study of common-sense knowledge, and the ways in which ordinary members of society “make sense of, find their way about in, and act on the circumstances in which they find themselves” (Heritage, 1984, p. 4), the discipline of conversation analysis (CA) was started by the late Harvey Sacks in 1960s California, along with his collaborators – Emanuel Schegloff and Gail Jefferson (ten Have, 1986).

CA focuses on the detailed study of “talk-in-interaction” (Schegloff, 2007a, p. 1). CA’s position with regard to human interaction is that it is “organizational and procedural” (ten Have, 1986, p. 9). As such, when people talk to each other, these are not individual and isolated acts, but are collectively co-

constructed in a manner that is organized and progressive. It is the role of the analyst, in turn, to examine *how* this collective co-construction is accomplished, rather than *why* the contributors to the interaction do what they do (ten Have, 1986).

In examining the *how*, CA pays specific attention to “sequence organization” in talk, the orderly set of actions that serve as the mechanism for getting things done in interaction. Core to analysis is the examination of “turn-taking” in conversations, described by Schegloff as “one of the most fundamental organizations of practice for talk-in-interaction” (Schegloff, 2007a, p. 1). The inspection of turns-at-talk (by those involved in the interaction while it is happening, as well as the analyst thereafter) helps us to “see what course(s) of action may be being progressively enacted through them, what possible responses may be being made relevant, what outcomes are being pursued, what sequences are being constructed or enacted or projected” (Schegloff, 2007a, p. 3).

In CA, talk-in-interaction is a “situated” achievement (ten Have, 1986), and one in which “context” is only considered to the extent that it is made manifest in interaction and, in turn, is co-constructed by the course of the interaction. As such, Heritage (1984) suggests that actions (including utterances) are both context-shaped and context renewing. In terms of the former, actions are context shaped in that any action in interaction “cannot be adequately understood except by reference to the context in which they participate” (Drew & Heritage, 1992, p. 18). This “context”, in turn, refers to both the *immediate*

context of the preceding activity, as well as the “larger environment” of the activity (such as the medical consultation). Actions are also context renewing, however, in the sense that any current action forms the immediate context of the next action, such that the context itself is co-constructed. Context is, therefore, viewed as a dynamic process that shifts and changes as the co-construction progresses.

While CA has yielded a vast array of analyses on mundane, everyday conversations, it has also produced a significant body of literature on “talk at work” – talk in institutional settings (Drew & Heritage, 1992). Drew and Heritage (1992) outline that CA in institutional contexts, such as the medical consultation, is based on the premise that “ordinary” conversation, which is seen the predominant medium of interaction in the social world, is not “abandoned at the threshold of the medical clinic” (Heritage & Maynard, 2006a, p. 362). Utterances as social actions in institutional contexts are still recognizably connected by the same stable patterns of sequences of action and, thereby, equally subject to the analysis of turns at talk.

Drew and Heritage (1992) suggest that what is “different” about institutional interaction compared to everyday conversation is that these involve the orientation of at least one party in the interaction to a goal or a task associated with the institution. Further, institutional interaction may be subject to “special and particular constraints” (Drew & Heritage, 1992, p. 22) germane to the business at hand. Finally, institutional interaction may be associated

with “inferential frameworks and procedures” that have particular relevance in that specific institutional context (Drew & Heritage, 1992, p. 22).

These criteria can be readily applied to the doctor-patient interaction, where the orientations to “doctor” and “patient” on the part of each respective participant form the categories - along with their categorical inferences and “category-bound activities” (see a discussion on Sacks’ work on membership categorization in Section 4.2.) – that facilitate the *doing* of the medical consultation. The medical consultation, in turn, is typically constrained by the medical business at hand and has a flexible, but ordered and sequential structure, all bound by the inferential framework of the Western or biomedical intervention.

Although the medical consultation is co-constructed - and the participants “talk [the] institution into being” (Heritage, 1984, p. 290) - this does not suggest that there is no pre-established framework for the medical encounter.

Conversation analysts recognize that there is, indeed, a structural framework for the medical encounter, but do not view it as “containing” the participants’ interactions in a static sense. ten Have (1989, p. 115) refers to this framework as an “ideal sequence for the consultation”, and Heritage and Maynard (2006a) refer to this as an “ordered structure of component activities…that is institutionalized in a fully sociological sense” (p.363) in that it is taught in medical schools, and many patients are exposed to it from infancy to adulthood. Rather than viewing this framework as something that “contains”

patients' actions, it is viewed as a "source of endogenously generated order that is realized in the doctor patient action" (Heritage & Maynard, 2006a, p. 363) and components of this structure have been used by conversation analysts to analyze the interactions of doctors and patients in different phases of the consultation. Broadly speaking, this ordered structure is composed of an opening sequence, problem presentation, history taking, a physical examination, diagnosis, treatment and a closing sequence (Heritage & Maynard, 2006a). Often within this consideration of the overall framework of the medical encounter, conversation analysts examine one or more of a variety of dimensions to conduct detailed studies of interaction at different phases (or all phases) of the doctor-patient interaction (Drew & Heritage, 1992).

The analysis in this study has also proceeded from an acknowledgement of the overall sequential structure of the medical consultation, although on account of the consultations under review being largely follow-up consultations (in which the chronic problem has already been identified, and the treatment is ongoing), the framework takes a somewhat different overall organizational structure, and tends to include: an opening, a review of regimen adherence, a review of laboratory results received and further tests required, a nutritional review against the child's pre-recorded weight and height history, a physical examination, a tuberculosis symptom check, referrals for other paediatric services (such as dentistry services) available within the hospital, next appointment scheduling, and closure.

In addition, however, several of the consultations also include additional components in the organizational framework - including inquiries into the child's social, educational and developmental wellbeing – as well as inquiries into whether or not the mother has access to one or more social support grants. As such, the overall structural organization of these consultations includes more obviously "medical" components, as well as the "social" components that consider more general socio-economic wellbeing.

In the analysis in Section 5, it emerges that the components in which the medical and the social blur tend to provide the impetus for the playing out of orientations to "motherly" and "doctorly" responsibilities.

4.2 MEMBERSHIP CATEGORISATION ANALYSIS

While CA has been viewed as the "crowning jewel of ethnomethodology" (Housely & Fitzgerald, 2002, p. 59), MCA also has it roots in Sacks' work. Sacks' often cited discussion of a part of a child's story, "The baby cried. The mommy picked it up", provides an elegant example of Sacks' membership categorization paradigm (see, for example, Schegloff, 2007b, Housely & Fitzgerald, 2002, and Stokoe, 2006). According to Sacks, we link the "mommy" and the "baby", and also hear that the "mommy" is the "mommy" of the "baby". Here the "membership categorization device" or MCD – one or more collections of categories (Schegloff, 2007b) is the "family" which ties the "mommy" and the "baby" together. Schegloff (2007b), in turn, drawing on Sacks' work, describes categories, as having three specific facets. Firstly, they are "inference-rich" and act as the "store house and the filing system for

the common-sense knowledge of ordinary people" (p. 469). Secondly, they are "protected against induction" in that those contravening what is known about any particular category are viewed as "'an exception', 'different', or even a defective member of that category" (p. 469), rather than provoking a revision of the knowledge of that category. Finally, activities are "category-bound" in that such that activities or actions are "specially characteristic of a category's members" (p. 470). Thus, the action of crying, for example, is tied to the category "baby".

In addition to MCDs and the facets of categories, Sacks also devised a set of "rules" that people employ in the application of categories. Amongst these are the "economy rule", such that "a single category term from any MCD can in principle do adequate reference", albeit that more than one can be used. The "consistency rule" in turn, holds that if a category has been used to refer to some person (on some occasion), then "other persons in the setting may be referred to or identified or apperceived or grasped by reference to the same or other categories from the same collection" (Schegloff, 2007b, p. 471).

Albeit that categorization formed a core component of Sacks' work, MCA has been described as the "milk float" to CA's "juggernaut" (Stokoe, 2012, p. 278), and has largely been relegated to the sidelines. Housely and Fitzgerald (2002) have argued that one of the reasons for MCA's relative neglect lies in the mistaken assumption on parts of the CA community at large that Sacks abandoned his earlier work on categories in favor of a focus on the sequential organization of talk. Others have suggested that MCA's relative neglect has

also been as a result of Schegloff's critique of the "promiscuous" use of MCA in analysis that "imports and imposes common sense knowledge" (Stokoe, 2006, p. 472) on the part of the analyst, rather than by showing how participants themselves orient to categories and engage in the process of categorization. For Schegloff (2007b), the CA commitment to empirical evidence internal to the data means that "if we want to characterize the parties to some interaction with some category terms, we need in principle to show that the parties were oriented to that categorization device in producing and understanding – moment-by-moment – the conduct that composed its progressive realization". In doing so, Schegloff (2007b) suggests that it is the role of the analyst to examine how participants in an interaction "make accessible to one *another* these orientations, because that is the most serious and compelling evidence of their indigenous-to-the-interaction status (Schegloff, 2007b, p. 475, emphasis in original).

MCA has recently shown resurgence in usage (Housely & Fitzgerald, 2002, and Stokoe, 2006) and, moreover, there has been a reconsideration of the relationship between CA and MCA, and how the sequential organization of talk and the display of categories are tied to one another. Stokoe (2006), for example, has argued for an approach in which the "study of categories must be integrated into an analysis of the sequence-organizational structures of conversational action" (Stokoe, 2006, p. 471), and that both aspects inform each other. For Stokoe, it is not just that categories crop up in sequences, but that people can "*do things* with them. They can accomplish bits of interactional business by selecting particular categories, by describing people

in one way rather than another way, and by formulating and reformulating categories and descriptions" (Stokoe, 2006, p. 482, emphasis in original).

In a recent examination of the relationship between CA and MCA, Stokoe (2012) suggests that one of the other reasons why categorial work has been sidelined pertains to concerns about its "capturability" (p. 279), largely on account of the "inference richness" of categories, in which inferences may be "*implied*, but not overtly stated" (Stokoe, 2012, p. 282, emphasis in original). The challenge for the analyst, then, is to "*unpack* what is apparently unsaid by members and produce an analysis of their subtle categorization work" (p. 282, emphasis in original). In examining a set of interactions, Stokoe (2012) then demonstrates ways in which categorization enacted by participants can be systematically analyzed, using five guiding principles and 10 key concepts. The key principles include locating the sequential position of each categorial instance; analyzing the design of the turn in which the category becomes evident; and looking for ways in which the participants in the interaction orient to, build and/or resist the category (p. 280). The key concepts include Sacks' MCDs and concepts such as "category-tied predicates" (such as a "caring mother") and "duplicative organization" in which categories work within a unit, such as "mother" to "child" in the mother-child unit (Stokoe, 2012).

This analysis takes the position that *doing* categories and *doing things with* categories is fundamentally embedded in the organization of sequences. Moreover, this *doing* is essential to shaping and renewing the contexts in which actions take place, as shifts, alignments and re-alignments in

orientations to any particular category elicit further actions made relevant by these shifts, alignments and re-alignments. As such, this analysis employs both CA and MCA in the analysis of talk-in-interaction, and places specific emphasis on how participants display their orientations towards specific categories, as well as how they mutually construct these categories in the course of doing the sequential business of the medical consultation. In this instance, prominence is placed on the co-construction of the category of "good mother", and how this is worked up into an evidenced-based display of what doing "good mothering" involves.

4.3 ETHICS CONSIDERATIONS

Ethics clearance for the use of the data for the purposes of this study was obtained from the University of the Witwatersrand Human Research Ethics Committee (non-medical) in 2012. The original participants were not re-consulted about the way in which the data would be analyzed in the present study (namely, using CA and MCA as analytic tools), although it is noted that this study has been completed with the intent of adhering to the broad original objectives of the data collection process, which were to analyse the data with a view to considering communication in a health care setting for positive patient outcomes. As such, the informed consent given by the participants during the original data collection process was deemed to apply to the analysis conducted for the purposes of the present study.

The identities of the participants (where evident in the video and audio materials) are protected in the analytic process. Participants are not

mentioned by name (and are only referred to as “doctor” or “mother” in the transcripts) to protect the identity of doctors, patients, and parents participating in the consultations. If other individuals are referred to in the talk, pseudonyms are used to protect their identities. The name of the hospital is not specified.

5 ANALYSIS

This analysis considers two consultations (Case A and Case B), selected from the overall body of data on the basis of the strength of the evidence in these cases for the co-construction of the “good mother” in the doctor-parent-HIV-positive child patient consultation. As indicated previously, however, it is suggested that ways in which orienting to the “good mother” play out in these cases provide some insight into “identity-in-interaction” that goes beyond the idiosyncrasies of these specific interactions.

The examination of Case A forms the bulk of the analysis, and several extracts from the consultation are considered in detail. Extracts from Case B, a shorter consultation, are also examined, and the two cases together show strikingly different ways in which the co-construction of the “good mother” is enacted, as the interactions progress from one course of action to the next.

5.1 CASE A

The total duration of the consultation in Case A is 15 minutes and 19 seconds. The consultation is between a doctor, the HIV-positive mother of the HIV-

positive child patient, and the four-year old female patient. The consultation is a follow-up consultation, and reference is made to previous consultations close to the start of the consultation.

As specified previously, the overall organizational structure of the consultation includes specifically “medical” components (such as reviewing of test results, regimen adherence, and etc.) and also includes those that are less obviously “medical”. These are evident across at least eight of the 21 consultations between the different doctors, suggesting that they are purposeful and routine consultation matters that the doctors treat as worthy of being attended to, rather than incidental sideline matters to the consultation as a whole. As indicated, these include inquiries into the child’s social, educational and developmental wellbeing, and inquiries into whether or not the mother has access to one or more social support grants. These are important for the purposes of this analysis, as the blurring of the “medical” and the “social” in these instances appears to create one context in which orienting to the “good mother” is able to play out.

The first extract (Case A, Extract 1) examined below, is one of the instances in the interaction in which the “medical” and the “social” aspects of the consultation blur.

Case A, Extract 1

```
6     D:    Good (.) ok (.) .hh how how old is she now again?
7     M:    <She is> five, she is going to be five [years]
8     D:                                           [going] to
9           be five: ok
10    M:    Yes=
11    D:    =In June?
12    M:    M:::
13    D:    Ok (.) uh (.) is she in crèche or preschool (.)
14          or is she with you at home?=
15    M:    =<No> I didn't find any
16    D:    You didn't find one?
17    M:    <No> I don't like those crèche things
18    D:    ok=
19    M:    =I wish I was in Khayelitsha
20    D:    You in Langa hey?
21    M:    YEss
22    D:    Ok that's interesting. (.) um (0.5) alright now
23          (.) I'm just checking her (.) she's um on
24          treatment now for eight months?
```

After a sequence re-establishing the child's age close to the start of the consultation (lines 6 to 12), the doctor initiates an inquiry sequence in line 13 on whether the child is in crèche, pre-school, or at home with the mother. The doctor provides no specifically "medical" or even health and wellbeing-related reason for posing the question, and thereby leaves it open for the recipient to consider the possibilities of responding to the query as a bit of non-medical "social chatter", or as a matter that may have some specific import in the context of the consultation.

In line 15, the mother, whose child remains at home and not in crèche or school, responds to the inquiry by answering the "in crèche" option in the doctor's question with a "no", instead of the "at home with you" option with a "yes". In answering the question in this way, the mother is treating crèche as the preferred option, and thereby positions herself as accountable for the child

being at home with her. This accountability, then, warrants a justification on the part of the mother as to why the child is at home with her rather than in crèche, and the reason provided by the mother is that she "didn't find any" (line 15) crèches. As such, the mother positions herself as not being at fault for her child not being in crèche, because she has confirmed that she has actively sought out opportunities in terms of the preferred crèche option, but has failed. This failure is not put down to her lack of effort to find such an opportunity but, rather, that there are no crèches to be found, despite her efforts in this regard.

The doctor expands the sequence in line 16 by rephrasing the mother's response as a question – "you didn't find one?" – thus prompting further elaboration on the part of the mother. Orienting to the doctor's response to the explanation as somehow incomplete, the mother shifts from the crèches-not-found position, and offers an alternative explanation to account for her child being at home in the form of "I don't like those crèche things" (line 17). In working up to this point, the mother completes the action of taking a position on the motherly terrain of educational choices regarding her child, in which the child being at home is now construed as *preferable* to the child being in crèche. As such, she moves from a position of not finding, to a position of not wanting. Having oriented to the mother as responsible and accountable for decisions pertaining to her child's education, the mother has labored to provide a rationale for her choice that is potentially both adequate to the doctor, and aligned to her "good motherly" identity as responsible for her child's developmental wellbeing.

The doctor's closing third to the adjacency pair is an "ok" (line 18), marking acceptance of the position just enacted. In line 19, however, the mother expands the sequence. Immediately after the doctor's "ok", the mother declares "=I wish I was in Khayelitsha" (line 19). The reason for this "wish" is not expanded on, but it is suggested that this is an attempt on the part of the mother to reformulate and reconcile her previous no-crèche explanations, so as to tie up the loose ends in her shift from not finding to not wanting. It is established in lines 20 and 21 that the mother is from Langa – the place in which no crèches were found. Her "wish" to be in Khayelitsha, then, suggests that there is something positively different about crèches in that alternative place which would allow the mother to re-consider crèche options for her child. As such, the mother seeks to resolve her no-crèche-found position with her "I don't like those crèche things" position (line 17) in a manner that returns to orienting to crèche as the preferred option, but only in circumstances in which the crèches available would meet her standards as a "good mother", as responsible for making decisions on the best options available for her child in her given context.

The doctor, however, does not collaborate in further talk on this "wish", and responds only to the "Khayelitsha" component of the turn. In line 20, the doctor treats it as confirmable that the mother is from somewhere else, other than Khayelitsha - "You in Langa hey?" – but does not collaborate in the uptake of further crèche talk, and the sequence is brought to a close.

In this short extract, then, being posed a question - the broadly “medical” or ”social” frame of reference of which is not made clear to the recipient - the mother has covered her motherly bases. She has explicated on her efforts to find a crèche, declared “those crèche things” unsuitable from her perspective as a mother, and reconciled her two accounts by presenting the possibility of considering other crèche alternatives, were she in a different community, with different crèche offerings.

In Extract 2 below, the issue of the child at home re-emerges in an inquiry sequence initiated by the doctor on whether or not the child has friends (line 277). As in the previous extract, whether the question has any bearing on the child’s wellbeing (“medical”) or whether it is a non-medical or social inquiry is not made clear to the mother.

```
Case A, Extract 2

277   D:    °Okay° (.) has she got friends?
278   M:    <Actually she got friends but they> they go to
279         school: and then she stay with me:: the whole day
280   D:    They (.) they (.) all of them or
281   M:    No I always go and fetch the friends and bring
282         the house >I got lot of toys< I always buy a lot
283         of toys (.)↓e::h
284   D:    Okay
```

In what Schegloff (2007a) terms a “proforma agreement”, the mother answers the doctor’s friend question with a “yes, but” type response in lines 278 and 279, confirming that the child *does* have friends, but that they go to school, whereas her child stays at home. The mother emphasizes that the child is with *her* (in the elongated “me::”) the “whole” day (line 279). The exclusive “with me::” (and therefore not with anybody else) and her emphasis on the

“the whole day” suggests an orientation to this state of affairs as something of a motherly burden in relation to the demands of caring for a child who is not in crèche, and is therefore the mother’s responsibility *all* of the time.

In line 280, the doctor follows up, not by responding to the “me:: the whole day”, but to its corollary – the absence of others – and invites her to confirm whether or not *all* of the friends that she has referred to are in school and, as such, whether or not the child has the opportunity to interact with *any* friends at *any* point in the “whole” day she is with *her*, the mother. The doctor’s inquiry in this regard now makes the topic of interaction with friends pointed, and moves it clearly out of the realm of casual social chatter. The mother, then, orients to the doctor’s line of inquiry on friends as one of import, and one that asks her to account for her responsibilities as a mother to ensure that her child has opportunities for social engagement with her peers.

Instead of dealing with the question of whether or not all of the child’s friends are in school, the mother responds to the possible charge on the doctor’s part of a friend problem by explaining her already-enacted solution to the friends being in school, which is to “always go to fetch the friends and bring the house” (lines 281 and 282). The mother, then, implicitly confirms the doctor’s inquiry about all the child’s friends being in school, but resists the potential construal of a problem in this regard, by elaborating on her active motherly interventions to overcome the potential problem.

In lines 282 and 283, the mother expands this active “good motherliness” to include the provision of toys, noting the emphasis on “I” in the “>I got a lot of toys<” and the emphasis on her role, as a mother, in buying these - “I always buy a lot of toys (.)”. As such, the mother has made an association between the issue of the child’s social interaction and her role in facilitating this through the provision of toys for social play. As in line 281 with the fetching of friends, the word “always” is used again in the reference to toys. This suggests the employment of what Pomerantz (1986) refers to as an extreme case formulation (ECF) – the practice of using “extreme” words and terms (such as “forever”, “every time” and “always”) to legitimize some claim made in the process of interacting with another. For Pomerantz (1986), one of the uses of extreme case formulations is to “assert the strongest case in anticipation of non-sympathetic hearings” (p. 227), and the “always” used by the mother in the instances examined above resonates with this “strongest case” scenario, in which the mother works to avert the construal of a problem on the part of the doctor by communicating her ongoing devotion and consistency in meeting the obligations of her motherly role.

In the above extract, then, the mother has recognized the doctor’s elevation of the problem of social interaction, has sought to address it by confirming her attention to the matter in the form of friend-fetching, and has added in further elements of her purchase of toys to facilitate social interaction in order to dispel any notions that the child is left socially isolated at home. The doctor closes the sequence in line 283, with an “okay”, betokening his acceptance of the elaboration.

In Extract 3 below, the nutritional assessment of the child-patient takes place in the consultation. While the nutritional wellbeing of the child fits more comfortably into the "medical" than crèches and friends do, it also falls heavily within the terrain of "good mothering", and this extract shows more plainly the interplay of "doctorly" and "motherly" orientations.

Case A, Extract 3

311	D:	And how is it going with the eating (.) because
312		<last time> Doctor Jones says something uh (.) that
313		(1.0) that she doesn't like (.) course food
314	M:	She only eat Weet-bix and oats=that's all
315	D:	Really:
316	M:	Weet-bix: I must buy Weet-bix=°>she doesn't want a
317		porridge for a meal<° (.) she want
318		Weet-[bix]
319	D:	[((inaudible))]
320	M:	She want Weet-bix (1.0) in the mornings (.) and
321		afternoon (.) and evening
322	D:	All she eats
323	M:	She eat Weet-bix and oats (.) that's all
324	D:	Really?
325	M:	M:::
326	D:	Does she like fruit and veg?
327	M:	(.) no↓
328	D:	Chicken (.) meat (.) fish?
329	M:	No=she doe=you can you can cook ↓neh (.) the rice
330		and and everything and veg there and you put
331		some=she doesn't want to eat meat and then she
332		will eat her veg only. (.) She doesn't want to eat
333		her rice .hh And tomorrow she gonna eat a plain
334		rice. No veg. No nothing=must put a plain thing
335	D:	°Alright° shoo cos we'd like her to get (0.5)
336		°some different foods° than (0.5) Weetbix (.) and
337		(.) rice (.) U::m would it be useful to (8.0)
338		((inaudible)) Would it be useful to speak to a
339		dietician: (0.5) and maybe um just to (.) give
340		you some advice (.) about trying different foods?
341		and and and see why she's not tolerating (.) um
342		pieces of food?
343	M:	(0.5) °Okay°
344	D:	Maybe we can do that=is that okay?
345	M:	°Okay°
346	D:	Because I see (0.5) last time they (1.0) did she
347		give you an appointment? °She didn't give you an
348		appointment:°
349	M:	M::: m:::

In lines 311 to 314, the doctor initiates a question-answer sequence that asks the mother “and how is it going with the eating”, referring to the *child’s* eating, and orienting to the mother as the child’s nutritional “provider”. After a brief pause, and before the mother is presented with the opportunity to respond, the doctor proceeds by referring to another doctor’s assessment of the child, which specifies “that (1.0) that she doesn’t like (.) course food” (line 313). As such, and unlike the crèche and friend lines of questioning, the doctor provides the medical basis for the question of good eating, based on the prior identification, by another *doctor*, of a food problem.

The mother responds to the doctor’s question by confirming that the child “only eat Weet-bix and oats=that’s all” (line 314). As such, the mother is aligning to the doctor’s assessment of a food problem, but is framing this as what the *child* chooses to eats, and not what the mother offers her, thus treating the problem that has been identified as a failure on the *child’s* part to eat other things. The mother’s assertion is another example of the use of an ECF. However, in this instance, its use is not to convince the doctor that the child only eats “Weet-bix and oats”, but to formulate the response as a complaint, and to use the extremes “only” and “that’s all” to make the issue of what her child eats legitimately “complainable” (Pomerantz, 1986, p. 227).

The doctor expands the sequence by his “really” in line 315, serving as a mild challenge that seeks confirmation and/or further explanation, which the mother takes up in line 316, elaborating on and re-confirming the child’s

insistence on Weet-bix but beginning, at this juncture, to propose that other offerings are made, albeit that these are refused: “she doesn’t want a porridge for a meal<° (.) she want Weet-bix”, lines 316 to 318. This is also an extension to the ECF that she has initiated to complain about the child’s insistence on only Weet-bix and oats. The mother is therefore confirming Dr. Jones’ assessment of food troubles, and is also beginning to distance herself from culpability in this regard by complaining about the child’s insistence on this, and only this food, all of the time. This is re-emphasized in lines 320 and 321: “She want Weet-bix (1.0) in the mornings (.) and afternoon (.) and evening”, a further expansion to the extreme case she has been formulating.

In line 322, the sequence is expanded again when the doctor challenges the mother a second time to re-confirm that this is all the child eats, suggesting that he has received the mother’s response as somehow not passable or unsatisfactory. The mother re-confirms her previous “she eat Weet-bix and oats (.) that’s all” in line 323, again positing her response as a complaint about the child’s problem eating, and not expanding further. Displaying dissatisfaction with this repeated re-confirmation, the doctor – now for the third time – responds with another “really?” in line 324, thus bringing further pressure to bear on the mother for some alternative type of response that she is not offering. The response from the mother, however, remains in line with the previous repeated confirmations, with no elaboration, in the form of “m:::” to betoken “yes” (line 325). To this point, the mother has aligned herself to the doctor’s assessment of a food problem, has treated the problem as one attributable to the *child* and, further, has treated the problem as

"complainable" about on her part as the mother. The doctor's progressive pursuit of some *other* response – one that is more passable – has not yet gained traction.

In line 326, the doctor changes his tack from general challenges, such as "really?" to more specific food-type questions, starting his fourth attempt at interrogating the mother with "does she like fruit and veg?". The mother's unequivocal response is a "no", thus still resisting the doctor's challenge for some *other* type of response. The sequence is expanded again with a further list of food-types from the doctor: "chicken (.) meat (.) fish?" (line 328). This is the fifth time in this component of the interaction that the doctor has progressively challenged the mother, all of which the mother has hitherto responded to with re-confirmations of the child's eating problem. At this point, the mother shifts her response strategy in the face of the doctor's repeated and progressive refusal to treat her claims about her child's eating problem as credible, thus leaving her good motherliness in doubt. In lines 329 to 334, the mother abandons her focus on the child's eating problem, and now responds to the doctor's insistent probing by shifting her focus to an elaboration of what she has done, as a mother, in order to address the child's eating problem. She describes cooking and presenting to her daughter, *inter alia*, two of the food groups specifically raised by the doctor ("meat" and "veg") and then, instead of repeating the "Weetbix and oats" only position, which has not, to this point, received acceptance by the doctor, the mother commences to describe her daughter's more general fickle eating habits of accepting one thing today (like "veg"), and refusing the same tomorrow, emphasizing that

these good foods are all *prepared* and *offered* by the mother in the first place, and only sometimes accepted by the child.

Thus, in the face of the doctor's resistance to accepting the mother's repeated confirmation of the child's eating problem, the mother eventually seeks an alternative response strategy as a means of seeking an end to the repeated question-answer sequences that has placed her credibility in doubt. In this alternative strategy, the mother moves away from the position that her child insists on only eating certain foods, towards an I-do-everything-possible-as-a-mother position.

Finally, the doctor indicates an acceptance of the mother's elaborations with an "°alright°" in line 335, followed by an evaluative "shoo" directly thereafter. Having just accepted the mother's claims of her child's eating problem – and only after the lengthy pursuit of an alternative explanation, which is ultimately not forthcoming (in that the mother's eventual explication of her efforts to address the food problem only serves to confirm that the problem lies with the child) – the doctor's "shoo" betokens his orientation to the difficulties of having a child with an eating problem. It also serves as something as a backward-looking justification of why he pressed so doggedly for an alternative explanation, as the intractable nature of an eating problem on the part of the child requires some other intervention - one not so easily addressed by better efforts on the part of the mother.

This then sets the stage for orienting to the “medical” rather than the “mother” for some resolution. Appealing back to the community of medical/health practitioners serving the facility (indicated by the “we” in “we’d like her to get (0.5) °some different foods°” in lines 335 and 336) the doctor raises the possibility of the mother consulting with a dietician. Instead of directly recommending the services of the dietician, however, the doctor asks the mother whether or not she thinks it would be useful to speak to a dietician in lines 337 and 338: “u::m would it be useful to (8.0) ((inaudible)) would it be useful to speak to a dietician:”. When the mother agrees with the suggestion after a brief pause (“°okay°” in line 343), the doctor responds with a hesitant “maybe” we can do that (line 344), and once again seeks the mother’s approval of the suggestion (“is that okay?” in line 344).

This suggests something of an orientation towards respecting the mother’s authority on matters of her daughter’s eating, although the doctor’s tentativeness also suggests reluctance on his part to concede that the problem requires a medical intervention. Having conceded, however, the doctor cautiously positions the suggested route as a *suggestion*, and orients towards the “authoritative mother” in doing so, leaving the final decision as up to her to agree to or reject.

In Extract 4 below, the consultation moves from food troubles to dental care, now well within the domain of the medical.

```
Case A, Extract 4

349   D:    Did she give you (0.5) °the dentist° (0.5) dentist
350         (1.0) last year August?
351   M:    M::
352   D:    Did she go then?
353   M:    Yes (.) They pull out the other thooth
354   D:    They pulled out the tooth: (0.5) Oh that's owwww
355   M:    Yes ((laughs))
356   D:    Does she brush regularly?
357   M:    Ye::s she got a lot of brushes and I buy her
358         colgate (.) children colgate you know?  She
359         doesn't use mine
```

In line 349, the doctor inquires whether or not "she" – the receptionist – gave the mother a dentist appointment for the child the previous August. The mother replies in the affirmative in line 351 with a "m::". Not assuming that the appointment was kept, the doctor initiates a follow-up question-answer sequence in which he asks if the appointment was, indeed, kept. The mother affirms that it was, and elaborates that this resulted in the extraction of a tooth. In line 356 the doctor probes further on the child's dental habits in "does she brush regularly?". Given that the child is four years old, however, (a fact that is established in the opening sequence at the start of the consultation) the question is implicitly about the *mother's* management of the child's dental habits. The mother responds with an elongated and emphatic "ye::s" in line 357, followed by work to confirm her orientation to this hygiene aspect of her "good motherly" role. This is done firstly by referring to her child's supply of "a lot of brushes" (line 357), serving to confirm that the mother takes tooth brushing seriously, and has gone above and beyond what is required in terms of making the necessary tool (a single toothbrush) available. The mother then also reports that she buys "colgate" (a brand of toothpaste) and then, after a brief pause, initiates a repair to specify that this is "children's colgate" (line

358), specially designed for children and, as such, that she is making every effort to ensure that her child's dental hygiene is catered for with all due consideration of what is best available and appropriate for her age. The mother further reinforces the manner in which she goes out of her way – as a good mother - to be child-centered in addressing her child's dental hygiene, by re-emphasizing that the child does *not* use *her* toothpaste, which is not designed specifically for children.

Extract 5 below takes place during the examination component of the consultation, with an initial pause in talk of 20 seconds, during which the doctor examines the child.

```
Case A, Extract 5

367   D:    (20.0) Ears aren't runny hey?
368   M:    M: m: (0.5) I don't think=
369   D:    =Anyone got TB at your house?
370         (1.0) Your neighbors got TB?
371   M:    (0.5) Neighbor (1.0) You know (.) how long (.) she
372         been eat eating the treatment? (0.5) It's a (.)
373         almost near a year now:
374   D:    She started again because (.) why? (1.0) He doesn't
376         drink pills proper (.) He always=
377   D:    =Does he miss some time?
378   M:    Yes (.) I mean sometime because he stay alone:
379         and the::nn:: forget his pills for a week: (2.0)
380         Now they say they going to start again to ma to
381         to to take the pills
382   D:    Is he still coughing and sweating?
383   M:    No: nothing
384   D:    She doesn't cough though?
385   M:    Uh uh (2.0) I keep my house clean e::very day:=You
386         can see when you go there=Don't worry=
387   D:    =I'm sure you do=
388   M:    =.hh don't worry ((laughs))
389   D:    No=no
390   M:    .hh no flies=no nothing there: ((laughs))
391   D:    I am not worried about TB and I'm not worried
392         about your house
```

In line 367, the sequence starts with the doctor inquiring about whether or not the child has “runny” ears. The questioned is posed so as to presuppose a “no” response – “ears aren’t runny hey?” – suggesting the anticipation of a report of no problems in this regard. In line 368, the mother responds with an initially aligned and unequivocal “m: m:” but then, after a pause, softens her immediate response with a more tentative “I don’t think”. In this sequence, the doctor has not explicitly stated that the “runny” ears line of questioning forms part of a tuberculosis (TB) symptom check. However, when the mother’s “runny” ear response shifts from the unequivocal “m: m:” to a more tentative response, the doctor orients to doctorly thoroughness in considering a possible TB infection.

Acting to consider the possibilities of potential infection sources, in line 369 the doctor initiates a line of inquiry about the presence of TB at the mother’s house – potentially TB infected inhabitants who would be in closest proximity to the child. After a brief pause before the mother responds, the doctor extends the query to any “neighbors” with TB, thereby widening his coverage in the exploration of possible TB-infected persons in close proximity to the HIV-positive child.

The mother confirms the presence of a neighbor with TB and, after a pause, elaborates on the neighbor’s poor regimen adherence (lines 371 to 381). In line 382 the prior discussion about the neighbor’s TB culminates with the doctor asking whether or not the neighbor is still “coughing and sweating”, both of which are considered to be clear observable symptoms of TB. The

mother ends the sequence by confirming that this is no longer the case. To this point in the TB line of questioning, the doctor has responded to tentativeness on the part of the mother on the question of “runny” ears, and has engaged in an exploration of possible sources of TB infection inside and around the child’s home. The mother’s uptake of the TB talk has specifically been on the subject of the neighbor – someone outside of her home – and she has not yet explicitly linked the line of questioning to how this TB outside her home could be implicated in a possible TB infection on the part of her child.

In line 384 the doctor returns his attention to the child patient, initiating a new, but linked sequence, in which he asks whether or not the child coughs, the matter of “coughing” now clearly linked to the previous set of sequences on the neighbor’s TB. Again, the doctor poses the question in a manner that pre-supposes a “no” response – “she doesn’t cough though?” – suggesting that his TB line of questioning seeks more to systematically exclude the possibility of TB rather than confirm the likelihood TB.

In line 385 the mother responds to the yes/no interrogative sequence by responding in the negative with “uh uh”. What follows thereafter is a significant two-second pause, followed by the mother’s seemingly incongruous initiation of a sequence on good housekeeping in lines 385 and 386: “(2.0) I keep my house clean e::very day:=you can see when you go there=don’t worry=”. What starts here, and becomes further evident later in the expansions to the sequence, is that the mother has now linked the questioning about her child’s

coughing or not coughing to the previous line of TB questioning and, moreover, has made an association between the possibility of her child having contracted a TB infection (which the doctor has yet to confirm or disconfirm) with a lack of cleanliness and, specifically, a lack of cleanliness in *her* home. These links and associations having been made, the mother then initiates a sequence to dispel any notion on the part of the doctor that she is in any way culpable for a possible TB infection on account of household uncleanliness through *her* neglect. The mother, then, is treating the doctor's prior questioning as implicating her in the possible spread of TB infection, and is working to reclaim her good standing as a mother who is responsible for keeping her domain – her home – clean and disease-free for all those, including her child, who dwell in it. As such, despite the mother's confirmation of the presence of a TB-infected neighbor (the most likely medical source of the possible TB infection emergent in the interaction) the mother's focus is entirely on defending her reputation with regards to her home, in which she does everything possible to keep the uncleanliness that she has associated with TB out of.

Evidence of her defensiveness emerges in her firm assurance that she cleans the house "e::very day:" (line 385), after which she offers up the opportunity for the doctor to come and view evidence of this ("you can see when you go there" in lines 385 and 386) and then provides a final assurance "don't worry" (line 386), followed by the doctor's hasty interjection "=I'm sure you do=" in line 387, by way of providing assurance about the emerging concern. After an audible inhalation, the mother repeats her "don't worry" assurance in line 386,

followed by a laugh. Again, the doctor attempts a repair in line 389 with a "no=no", an expression of that-is-not-what-I-mean, but the mother expands the "good housekeeping" sequence again with further guarantees that in her home (again after an audible inhalation that appears to indicate the charged nature of the conversation for her) there are "no flies=no nothing there: ((laughs))" in line 390. Despite the doctor's repeated assurances that he is not concerned about cleanliness on the part of the mother, she has nonetheless persisted with her cleanliness claims, has maintained the association between TB and cleanliness, and has strongly oriented to "good mother" in declaring her attention to her role in keeping things clean. She is defending against any suggestion of "mother as infector" – even though the doctor refutes this – by orienting to "mother as protector", and firmly establishes her footing in this regard.

The doctor seeks to end the sequence in lines 391 and 392 by being more emphatic that he is neither concerned with TB or the woman's house. She responds with further inhalations and laughter, but does not re-open or further resist the closure of the sequence, and the doctor moves directly on to the next course of action, and begins writing in the patient file.

As indicated in the introduction to this analysis, one of the components of the overall structure of the consultations under review here involves assessing whether or not the mother or guardian has access to grant monies to assist with the care of the child. Extract 6 below, the final extract examined from Case A, contains two expanded sequences, the first in which the course of

action revolves around a request on the part of the mother to borrow money from the doctor (lines 407 to 423), and the second of which pertains to whether or not the mother is receiving a social support grant (lines 424 to 438). The two expanded sequences, although discrete, are also linked, and the actions that play out in the first expanded sequence – albeit not directly illustrative of an orientation to "good motherliness" – provide an interesting backdrop for the analysis of the second expanded sequence.

Case A, Extract 6

407	M:	(6.0) Can you ask you something that I never ask
408		someone ((laughs)) .hh (.) uhh (0.5) I (.) I (.) I
409		really uh owe some <monies:::> to a (.) to
410		somebody .hh so if perhaps you can s:: (.) I
411		never ask=>I'm totally embarrass<
412	D:	[u::m]
413	M:	[I'll] bring it [back]
414	D:	No [no no]=that's okay (.) um let me
415		<see> (.) When you go down S4 (.) past the ramp
416	M:	Ehh
417	D:	You know the secretary there
418	M:	Ehh
418	D:	She does give taxi fare
419	M:	Okay °so° (3.0) I am so embarrass ((laughs))
420	D:	>No no no< (.) It's fine (.) It's fine
421	M:	.hh I never do that
422	D:	How much is the taxi fare?
423	M:	It's uh (.) it's twenty rands
424	D:	uhmm (1.0) are you getting a grant (.) um (.) for
425		the=
426	M:	=for the child?
427	M:	yes=not mine=I don't need it now:
428	D:	but is she getting one?
429	M:	yes yes yes
430	D:	°good°
431	M:	(0.5) I buy her medicatio::n so that like uh
432		multi vitamin::s (.) clothes=I don't use it (0.5)
433		you know how other mommies how they like to take
434		the money and then use only (.) um (.) in their
435		province and then you (.) you see the child=he is
436		at grans=he doesn't have food at home (.) you
437		see?
438	D:	°I can believe that°

The mother initiates the first sequence under review in line 407. The transition from the previous sequence to the commencement of this sequence takes place while the doctor is updating notes in the patient's file. After a six second pause in talk while this is taking place, the mother initiates the sequence with: "(6.0) Can you ask you something that I never ask someone ((laughs))". As such, the mother sets the scene for the making of a delicate request that possibly extends the bounds of what it might be acceptable to request, and orients her position to that kind of someone who would never normally do this, and that this is a distinctly atypical action on her part.

What follows this is a set of prevarications and delays (nervous laughter, followed by an audible inhalation, an "uhh" and a stuttering set of "I"s punctuated by brief pauses), which provide further evidence of the delicacy or awkwardness of the request that she is building up to. In line 409 the mother then starts to formulate the atypical request, albeit that the doctor has not responded to the initial request to make the request - his silence conceivably indicating a tacit resistance to having to deal with the atypical request that might follow. The atypical request, in turn, is not fully articulated as a request directed at soliciting a yes/no response. Instead, it takes the form of an explanation about why the request is going to be made in lines 409 and 410: "(0.5) I (.) I (.) I really uh owe some <monies:::> to a (.) to somebody", followed only then by the beginning of the action to perform the request – "hh so if perhaps you can s:: (.)" - in line 410, the final "asking" of which is not completed, and followed by a hasty resumption of the this-is-atypical-for-me

orientation - “I never ask” - and a rapidly spoken declaration of embarrassment to reinforce that – “=>I’m totally embarrass<”.

The doctor’s response is turn-initial delay - the drawn out prevarication “u::m” in line 412 – suggesting the start of the formulation of a “dispreferred” response (Schegloff, 2007a) that will result in the denial of the request. Projecting the possible denial, the mother interjects (line 413) and states that she will bring “it” back, the “it” ostensibly referring to the incomplete request for money that the doctor has yet to respond to. In this instance, the “I’ll bring it back” takes the form of a “preemptive reformulation” (Schegloff, 2007a) in the face of possible denial, that serves to reformulate the unfinished request as a loan, and not a donation, in anticipation that this might change the resultant response on the part of the doctor.

The doctor’s response to the atypical request sees him orient to the institutional. There is no collaboration on, or take-up of, the foundation of the request – the owing of “some <monies:::> to a (.) to somebody” (line 409). Instead, the doctor distances himself from the request, without explicitly rejecting it, after a delay - “(.) um let me <see>” - in lines 414 and 415. Instead of providing a response to the specific request for money-giving-so-that-the-mother-can-pay-back-the-someone-who-she-owes, the doctor chooses to selectively hear and address only the money-giving component of the request and, moreover, does so by orienting to the institutional and responding to the money-giving component of the request in terms of only what *the institution* can and does provide – taxi fare. This is followed by the action of diverting

and referring the request through direction-giving to the facility's secretary who will "give taxi fare" (line 418). In this way, the doctor conveys that the request for money – atypical of the mother or not – has been misdirected at the "doctor" part of the institution, and requires referral to the appropriate institutional point - the facility's secretary who is located "down S4 (.) past the ramp" (line 415). The mother does not, at this point, initiate a repair in order to re-clarify the request, and appears to decide to collaborate with the reformulation that has taken place, as the sequence comes to a close.

The talk about money, however, ties into the initiation of the next sequence, in which the doctor – linking back to the previous talk of money - inquires about whether or not the mother has access to a grant (line 424). After some expansions in the form of repairs and responses clarifying whether or not she is receiving a grant for herself or for the child, from lines 431 to 438 the mother, having just moved through the awkward request for a loan sequence with the doctor, takes the opportunity of grant monies talk to redeem and re-construct her orientation as the "good mother", specifically in the context of the good mother who receives money in the form of a child support grant. Having confirmed that she is receiving a grant for the child in the prior question/answer sequence, in lines 431 and 432, the mother uses the opportunity of grant-talk to initiate an unsolicited elaboration on how she uses this grant money: "I buy her medicatio::n so that like uh multi vitamin::s (.) clothes". Here the mother is treating the grant money as money that should be used expressly for the *child*, and she is laboring to make known that this is precisely how she goes about using the grant money. She then buttresses her

claims by reinforcing that *she* does not use them money - "=I don't use it" in line 432 – for *herself*. In this elaboration, then, the mother is orienting to "good mothering" by building an identity of the selfless mother who uses the grant money only as it is intended – to support the child.

In lines 433 to 437 the mother reinforces her orientation towards constructing the good mother by drawing a contrast between her good motherliness and defective "other mommies" (line 433) who use the grant money in "their province" (lines 434 and 435) while the children, ostensibly living with their grandparents in provinces other than the mother's province, do not "have food at home" (line 436). This is followed with the mother seeking an aligned response from the doctor in "(.) you <u>see</u>?" in lines 436 and 437. The doctor concludes the sequence by aligning with the question with a subdued and quietly spoken "°I can believe that°" in line 438.

In this extract, then, there has been uncomfortable talk about money in which the mother has made a request for a loan from the doctor to pay back someone else to whom she owes money, and who she is ostensibly short of money to repay. The request has been diverted, but the interaction around the loan is followed by inquiries about the mother's access to a social grant, which is confirmed. What is left hanging, however, are potential inferences about the extent to which the shortage of money impacts on the mother's use of the social grant for purposes other than those pertaining directly to the child. The mother then acts to address the potential inferences that have been brought into relevance in the interaction by explicating on her grant-use. Orienting to

being the “good mother”, she elaborates on her use of the grant money, which she treats as *only* for the child, aiming to dispel any inference that her own money shortages may result in dipping into the special pocket of child-only financial support, despite her money troubles.

5.2 CASE B

As indicated previously, not all of the consultations are attended by the birth mothers of the HIV-infected child patients. There are cases in which the “mother” is replaced by a guardian and, in all instances in the data set, by a female guardian. In the extract from Case B below, it is the guardian of the HIV-positive female child who has brought the child to the consultation. At the start of the consultation, the child’s “mommy” is referred to, confirming that the guardian is not the birth mother, but it also becomes apparent that the guardian is the individual managing the child’s treatment and is, therefore, the caregiver or the “proxy mommy” in this regard (based on the category “mommy”, from which it is inferred that it is she who rears and takes care of the child). The mother’s whereabouts, and whether or not she is alive or deceased, are not discussed, and there is no direct indication in the consultation of whether the proxy mother is a relative or friend of the birth mother, or any other such eventuality. What can be safely assumed, however, is that the “proxy mommy” is very unlikely to have been transmitter of the HIV virus to the child.

Just prior to the commencement of the extract below, the doctor has noted that the child's returned test results indicate that the viral load is low, and that the virus is "under control".

```
Case B, Extract

1     Dr:   It also means:: (0.5) that you doing a ver:y good
2           job:
3     Gr:   (.)°Thank: [yoo::°]
4     Dr:              [You] are doing an exTREMEly good
5     Gr:   [°Thank you°]
6     Dr:   [job] okay? You are giving her the medicines as we.
7           (0.5) ordered=as we as we write it up: (0.5) hh and
8           this is what's keeping it dow[n:]
9     Gr:                                 [°Okay°]
10    Dr:   (.) hh s::o:: (.) you're doing an excellent job=so
11          you must (.) just continue:
12    Gr:   hhh ((°laughs°))
13    Dr:   Just (.) continue=continue=°continue°=
14    Gr:   °Okay°
15    Dr:   (2) The vi:rus attacks the the body=°okay°? it
16          destroys the CD4 cell: (.) the virus kills it off.
17          (.) The virus ki:lls that cells off:
18    Gr:   The=the what are the CD cells? I::t's=a=i::t's a
19          [whi::]
20    Dr:   [°CD4°]
21    Gr:   Whi::te cor[puscle]
22    Dr:              [>°Yes::°<]
23    Gr:   Bla::[ck]
24    Dr:        [°White°]
25    Gr:   =I mean the whi::te
26    Dr:   =White corpuscles
27    Gr:   The whi::te corpuscle (.) hh so the whi::te
28          corpusc[les]
29    Dr:           [S::o]
30    Gr:    hh >they=they=they=they=they< they (.) help any hh
31          (.) the human being >all that< (.) hh the=the=[the]
32    Dr:                                                 [Ja]
33    Gr:   The=the=the immune sys[tem]
34    Dr:                               [>ja=they<] (.) ja. It makes
35          the immune system strong. (.) They also fight
36          against col::ds and cou[ghs]
37    Gr:                           [Coughs]. (.) Ah °okay°.
38    Dr:   =And sore throats and tummy ache and diarrhoea °and
39          stuff like that.° hh (.) So when she came here: the
40          CD4 count was very low:
```

Line 1 in the extract is the doctor's post-expansion on the report-back on the child's test results in which the doctor, having confirmed the low viral load,

compliments the proxy mother on her role in this eventuality: “It also means:: (0.5) that you doing a ver:y good job:” (lines 1 and 2). As such, the doctor has oriented to the proxy mother as the individual responsible for the management of the child’s regimen.

The proxy mother’s response in line 3 is a quiet but elongated “(.)°thank: yoo::°”, in which she, in turn, also orients to her role as proxy mother, and accepts the doctor’s compliment about *her* contributions to the reduction of the child’s viral load. This acceptance of the compliment is interrupted with an overlap in talk, as the doctor, in lines 4 and 6, repeats the compliment, even more emphatically “you are doing an exTREMEly good…job” – interrupted just before “job” by another overlap in talk as the mother again accepts the doctor’s compliment with another quiet “°thank you°” in line 5.

In line 6 the doctor begins to expand on this “good job” on the part of the proxy mother, but firmly from the footing of the doctor. She is a good mother *because* she is giving the child her the medicines as “we ordered=as we as we write it up: (0.5) hh and this is what’s keeping it down:”, the “it” being referred to being child’s viral load (lines 6-8). The “we” that the doctor refers to is the medical “we” – the community of doctors and healthcare workers involved in the child’s medical treatment, and it is this medical community that has instructed the proxy mother what to do in terms of supporting the child’s treatment.

As such, the good mother being co-constructed here, then, is the mother who has followed the doctor's instructions to the letter – "as we write it up:" - and, in turn, it is this strict obedience to the doctor's instructions that has, according to the doctor, resulted in the success attained in the reduction of the child's viral load.

In line 10 the doctor once again re-affirms the proxy mother's good job in ensuring the child's adherence to the prescribed regimen - "(.) hh s::o:: (.) you're doing an excellent job" – and then provides the proxy mother with her next medical instruction, which is to "just continue:" (line 11). This instruction, while referencing the mother's management of the child's regimen in the immediate future, also serves as another compliment for what has been done by the proxy mother to this point. Her success in the application and management of the regimen requires no further doctorly adjustments or instructions, and her orders, as proxy mother, from the doctor are to "just (.) continue=continue=°continue°=" (line 13). The sequence closes in line 14, with the proxy mother claiming acceptance of these orders-given-as-compliments with an "°okay°" (line 14).

After complimenting the proxy mother on her adherence to doctor's orders, the doctor initiates a post-expansion of the previous sequence in line 15. Orienting to being the authoritative doctor, he commences to provide a medical explanation of the how the virus works (lines 15, 16 and 17). After the first component of the explanation – "(2.0) the vi:rus attacks the the body=" in line 15, the doctor seeks a confirmation that this has been understood in his

posing of his question “=°okay°?”. It is possible that the proxy mother provides some sort of non-verbal response at this point, but the mother is not in the visual frame of the video-recording, and so this cannot be ascertained. The doctor continues his explanation with, “it destroys the CD4 cell:”, followed by two further additions: “(.) the virus kills it off (.) the virus ki:lls that cells off:”, in lines 16 and 17. It appears that in this process, the doctor is attempting to craft this medical explanation in a manner that it is intelligible to, and understood by, the non-medically-trained proxy mother.

Further, in this explanation, the doctor appears to be providing the proxy mother with the medical description of what she has managed to achieve through regimen adherence, thereby supplying the medical motivation for her to “just continue:” (line 11) in pursuit of the desired outcome at a cellular level. The explanation also serves as an invitation to the proxy mother to engage in this medical space, and the proxy mother takes this invitation up from line 18. In her response, the proxy mother does not simply receive the previous explanation provided, but uses the invitation to engage further on how the virus works, both by asking for further explanations and by displaying and testing her own medical knowledge of the child’s condition. In line 18, the proxy mother responds to the “CD4 cell” component of the doctor’s explanation, and initiates a repair sequence in which she asks what the CD4 cells are. Not waiting for the doctor’s reply, the proxy mother begins to form the CD4 question into a statement – the answer to her own question – thereby testing her motherly knowledge of the virus with the authoritative doctor, but simultaneously providing a display that she possesses some medical

knowledge in the first instance, and knows that CD4 cells are “whi::te corpuscle” (line 21). In line 22 the doctor overlaps the proxy mother’s talk with an extended verification that this is correct – “>°yes::°<” - in line 22.

The mother then appears to initiate a self-repair, despite the doctor’s confirmation of her correct response, with “Bla::ck” in line 23, after which she is corrected by the doctor, and repairs back to white again. In line 30, the proxy mother again begins engagement in a “knowledge-testing” process, by proceeding to state her understanding of the role of the white corpuscles in the immune system. This is a faltering process of grappling to find the correct medical terminology - “hh >they=they=they=they=they< they (.) help any hh (.) the human being >all that< (.) hh the=the=the”. In line 33 the proxy mother hits on the terms she has been looking for and announces emphatically “immune system”. In line 34, the doctor confirms the “correctness” of the medical statements, and expands the explanation of the role of the white corpuscles.

Thus, in this interaction, the “good mother” has been applauded for her strict adherence to doctor’s orders, and has both been encouraged to continue her good work, as well as been rewarded for this good work, by an invitation on the part of the doctor to explore the medical basis of what she has achieved. The mother takes up the opportunity to engage in this regard, but not just as the passive “learner”. Instead, the mother uses the opportunity to achieve two things: to seek clarification on medical matters about which she is not certain and, critically, to do this by displaying and testing her already-existing

knowledge of the virus with the doctor. In this way, the proxy mother makes known her previous efforts to become educated about the chronic disease that the child has, and displays her continued interest in further developing this knowledge, thus laying claim to the “informed”, “attentive” and “caring” mother.

6 DISCUSSION

Some of the literature reviewed in this study (Bell, 2003, Kielty, 2008, and Johnston & Swanson, 2006) examines the ways in which mothers labor to construct, re-construct, align and repair their identities to justify continued membership of the “good mother” category, or to reclaim their membership of this category in the face of some challenge to, or compromise of, their “good motherly” standing. The present study has also considered literature on mothering in the context of HIV (Nelms, 2005, Sandelowski & Barroso, 2003, Ingram & Hutchinson, 1999a and Ingram & Hutchinson, 1999b), and how HIV-infected women seek to negotiate and reconcile their identities as “HIV-positive” and as “good mothers” and work to avoid stigma, to protect themselves and their children, and/or to reconcile the physical and psychological constraints of the disease with their motherly responsibilities.

These studies, then, give insight into the fluid nature of motherly identities, and the ways in which mothers act to construct and re-construct these identities to align with one or another good motherly ideal.

The present study has sought to provide particular insight into the way in which the labor of orienting to "good mothering" in *done* - in a moment-by-moment, collaborative and co-constructed manner – in the immediate course of naturally occurring interaction. Employing CA and MCA, this examination of talk-in-interaction in doctor-mother/guardian-HIV-positive child patient consultations has placed specific emphasis on how participants display their orientations towards specific categories, as well as how they mutually construct these categories in the course of doing the sequential business at hand. Prominence is placed on the co-construction of the category of "good mother", and how this is worked up into an evidenced-based display of what *doing* "good mothering" involves.

While the data used for this analysis were extracted from doctor-mother-paediatric patient consultations this is, in part, incidental. This study has examined how "identity-building" or "identity-shaping" is *done* in the immediate moment, even when the matter of the particular identity is *not* the main business at hand, but where doing that identity, at that moment, becomes relevant. Moreover, whatever is built on a moment-by-moment basis does not remain fixed and is, instead, oriented to, negotiated, shifted, claimed and resisted in a co-construction of every step or set of actions in the course of the interaction. It is suggested that although the interactions are circumscribed by their immediate context – and are analyzed as such – they do begin to provide evidence of how "identity work" is done when a particular "identity" comes to be at stake in an interaction. Further, it is suggested that the production of the "good mother" identity is something that could conceivably

happen in a range of other interactional contexts – albeit in different renderings that are subject to those specific contexts – when "good motherliness" becomes relevant and at stake for participants in the interaction.

At the broadest level, then, this study has sought to contribute to the MCA imperative of addressing the matter of "capturability" (Stokoe, 2012, p. 279) in relation to participants in an interaction *doing* categories, with all their associated inferences. The display of some orientation or another is not always overtly stated and, as is the case with the data analyzed here, can be "implied" (Stokoe, 2012). This study has aimed to unpack how inference-rich categories are brought into relevance by participants in an interaction, and how these categories are *done* and *enacted*, rather than declared. As such, the "good mother" is not an essential state, but something that becomes at stake at specific moments in an interaction. If this becoming at stake is taken up by the participants, the labor of orienting to and doing the category results in an interactional display that is "capturable" and, concomitantly, examinable.

In another way, however, the fact that the data examined are naturally occurring medical consultations is not incidental. CA has a long history of contributing to the examination of doctor-patient interactions, with a view to enhancing positive patient outcomes. These studies have considered the implications of the asymmetry of doctor-patient interactions (ten Have, 1995, Peräkylä, 2006 and Pilnick & Dingwall, 2011), considered how patients bring their own agendas to bear in the course of the interaction (such as Heritage &

Robinson, 2006, Robinson, 2006, Tees Gill & Maynard, 2006, and Drew, 2006), and how these, in turn, shape the course of the interaction (including a consideration of the interplay of the medical and the social, towards a "medico-social" course of action, as considered by Boyd & Heritage, 2006). Other CA studies have specifically focused on the ways in which parents contribute to shaping the course of the consultation (Tates & Meeuwesen, 2001), including ways in which parents assume responsibility for their children's health and, in doing so, silence their children in the course of the interaction (Tates et al., 2001). Finally, the doctor-parent studies reviewed here have even examined evidence of the ways in which parents impact on doctors' treatment decisions pertaining to their children, sometimes to negative effect (Stivers, 2002a, 2002b & 2006).

This study's contribution to the CA doctor-patient interaction gamut focuses specifically on *doing* the category of the "good mother" – sequentially enacted in the course of the interaction – in doctor-mother/guardian-HIV-positive child consultations. It points to ways in which "good motherliness" comes to be at stake for participants, and how the good motherly identity is "talked into being" (Drew & Heritage, 1992) on a moment-by-moment basis.

One area of particular interest in the doctor-child patient-mother interactions considered here pertains to actions to retain membership in one or other motherly "ideal" in a context in which the mother is both the "protector" and "infector". This ambiguity increases the stakes for claiming and re-claiming membership of the "good mother" category and, in one of the cases

considered here, sees repeated labor on the part of the mother to actively claim membership in this category, be it by building up to – and refining - declarations of her actions to make suitable educational and social choices for her child, or by articulating her detailed attention to matters of, for example, oral hygiene. Similarly, any inferences that she may *not* belong to the category of "good mother" are actively resisted by identity-making in interaction. Examples in this study include the mother resisting being implicated in her child's "food problem" and attempting to dispel the notion that she could in any way be implicated in her child contracting TB (through her "uncleanliness").

Further, when "good motherliness" is seen to be discredited in particular moments (such as the awkward request for a loan from the doctor) the mother labors to repair any damage done, and this repair takes the form of "good mother" identity building, rather than the myriad of possible alternatives and is, as such, clearly what is seen as at stake.

Also of interest are the interplays of "motherly authority" and "doctorly authority". The evidence considered here suggests that it is in interactional components in which the medical and social tend to blur that impetus is found for these orientations to play out. The question of a "food problem" on the part of the child examined here, for example, sees the doctor in pursuit of an explanation that might bring into question the adequacy of the mother as nutritional provider. The mother, however, pushes back, and resists the repeated attempts of the doctor to locate the reason for the food problem

within her ambit of responsibility, and results in the doctor eventually pursuing an alternative recommendation (a consultation with a nutritionist) that reaches beyond the mother's scope as provider.

While studies of doctor-child patient-parents interactions have produced evidence of how parents and doctors both co-construct the course - and, as some evidence suggests - the outcomes of the consultation, this study suggests that moment-by-moment identity-making and, specifically, identity-making in relation to belonging to the category "good mother" may also be a feature of the doctor-child patient-parent interaction that merits further exploration. The evidence here suggests that orienting to the "good mother" identity strongly shapes the course of the interaction, and an acknowledgement of the extent to which this may be at stake in other doctor-child patient-parent interactions prompts questions about the extent to which this may impact on doctor patient communication and positive patient outcomes.

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